Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH DBA INJURY 1-DALLAS
9330 LBJ FREEWAY SUITE 1000
DALLAS TEXAS 75243

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
UNIVERSITY OF TEXAS SYSTEM

Carrier's Austin Representative Box
Box Number 46

MFDR Tracking Number
M4-12-2312-01

MFDR Date Received
March 6, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT code 97530 was not paid and denied per EOB correct coding initiative bundle guidelines indicate this code is a mutually exclusive code, considered included in another code on the same day as code. CPT code 97530 is a separate procedure and is not global with any other code. Also, it was provided to decrease pain, increase flexibility and decrease stiffness."

Amount in Dispute: $104.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is this Carrier's position that no reimbursement is due for code 97530 per Medicare and Division of Workers' Compensation reimbursement methodology... Per the Center for Medicare Services (CMS) Correct Coding Initiative (CCI) code 97530 is a column 2 code to Column 1 code 97140 on the Mutually Exclusive Edits..."

Response Submitted by: UniMed Direct

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 14, 2011	97530	$104.06	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline reimbursement for professional services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 14, 2011 and July 22, 2011
   - 236 – This procedure or procedure/modifier combination is not compatible with another procedure
   - 509-001 – Correct coding initiative bundle guidelines indicate this code is a mutually exclusive code, considered included in another code on the same day as code

Issues

1. Did the requestor bill for CPT codes in conflict with CCI edit?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203 states in pertinent part "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
   - CCI edits were run to determine if the billed charges had NCCI edit conflicts.
   - The requestor billed the following CPT codes on June 14, 2011; 97530-GO, 97110-GO and 97140-GO.
   - Per CCI Guidelines, Procedure Code 97530 has a CCI conflict with Procedure Code 97140. A modifier may be appropriate under certain circumstances.
   - The requestor did not append modifier -59 to the disputed charge (with exception to modifier GO) to identify procedures/services that are commonly bundled together but are appropriate to report separately.
2. As a result, for the reasons stated above, the requestor is not entitled to reimbursement for CPT code 97530-GO.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 24, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.